| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

## Filing at a Glance

Company: Sterling Investors Life Insurance Company

| | | |
|---|---|---|
| Product Name: SILIC AR REV APP | SERFF Tr Num: WKLY-126013150 | State: ArkansasLH |
| TOI: MS06 Medicare Supplement - Other | SERFF Status: Closed | State Tr Num: 41402 |
| Sub-TOI: MS06.000 Medicare Supplement - Other | Co Tr Num: SILIC AR REV APP | State Status: Filed-Closed |
| Filing Type: Form | Co Status: | Reviewer(s): Stephanie Fowler |
| | Author: Karen Nowlan | Disposition Date: 02/03/2009 |
| | Date Submitted: 01/29/2009 | Disposition Status: Filed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: | Status of Filing in Domicile: Pending |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Group Market Size: |
| Overall Rate Impact: | Group Market Type: |
| Filing Status Changed: 02/03/2009 | |
| State Status Changed: 02/03/2009 | Deemer Date: |

Corresponding Filing Tracking Number:

Filing Description:

We have been authorized by Sterling Investors Life Insurance Company to file the attached revised Medicare Supplement/Whole Life Application on their behalf. A letter of authorization is included with this filing.

The revised Application will replace MSLAPP200612AR(State Tr Num: 34491) which was approved by your January 19, 2007. The following changes were made to the application:

1. Sections were added to obtain the date the applicant’s Medicare Part A was effective, who to mail the policy to and when to draft the first premium;

2. Health questions were revised;

3. A Primary Physician Information section was added;

4. A section was added to Part II for the Beneficiary's date of birth and for Contingent Beneficiary information;

5. Changes were made to the Medical Coverage Replacement section to aid in administration; and

6. HIPAA required language regarding re-disclosure of information was added to the Authorization section.

Thank you for your assistance with this submission. If you have any questions or require additional information please contact me at 1-877-777-2443, extension 2171 or by e-mail at karen.nowlan@iasadmin.com.

## Company and Contact

**Filing Contact Information**

(This filing was made by a third party - WAI01)

| | |
|---|---|
| Karen Nowlan, Compliance Analyst | karen.nowlan@wakelyinc.com |
| Wakely and Associates, Inc. | (727) 584-8128 [Phone] |
| Largo, FL 33773-1502 | (727) 584-5613[FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| Sterling Investors Life Insurance Company | CoCode: 89184 | State of Domicile: Georgia |
| 210 E. Second Avenue, Suite 105 | Group Code: -99 | Company Type: Life and Health |
| Rome, GA 30161 | Group Name: | State ID Number: |
| (706) 235-8154 ext. [Phone] | FEIN Number: 59-1838073 | |

---

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $20.00 |
| Retaliatory? | No |
| Fee Explanation: | |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Sterling Investors Life Insurance Company | $20.00 | 01/29/2009 | 25361514 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Filed | Stephanie Fowler | 02/03/2009 | 02/03/2009 |

### Amendments

| Item | Schedule | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Application | Form | Karen Nowlan | 02/03/2009 | 02/03/2009 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Disposition

Disposition Date: 02/03/2009
Implementation Date:
Status: Filed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

| Item Type | Item Name | Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Accepted for Informational Purposes | Yes |
| **Supporting Document** | Application | | Yes |
| **Supporting Document** | Health - Actuarial Justification | | Yes |
| **Supporting Document** | Outline of Coverage | | Yes |
| **Supporting Document** | Authorization Ltr | Accepted for Informational Purposes | Yes |
| **Form** *(revised)* | Application | Filed | Yes |
| **Form** | Application | | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

**Amendment Letter**

Amendment Date:

Submitted Date: 02/03/2009

**Comments:**

The attached replaces the application submitted earlier.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

| Form Number | Form Type | Form Name | Action | Form Action Other | Previous Filing # | Replaced Form # | Readability Score | Attachments |
|---|---|---|---|---|---|---|---|---|
| SIMSLAPP200901AR | Application/Enrollment Form | Application | Revised | | 34491 | MSLAPP200612AR | | SIMSLAPP200901AR.pdf |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Form Schedule

**Lead Form Number:** SIMSLAPP200901AR

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Filed | SIMSLAPP200901AR | Application/ Enrollment Form | Application | Revised | Replaced Form #: MSLAPP200612AR Previous Filing #: 34491 | | SIMSLAPP200901AR.pdf |

# STERLING INVESTORS LIFE INSURANCE COMPANY

**Home Office: Rome, Georgia  Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846**

**APPLICATION #:**

**APPLICANT** *(Exactly as shown on your Medicare ID Card)*

*Last*  *First*  *MI*

**Check the Medicare Supplement Plan You Prefer:**

- ☐ **Standardized Plan A**
- ☐ **Standardized Plan B**
- ☐ **Standardized Plan C**
- ☐ **Standardized Plan D**
- ☐ **Standardized Plan E**
- ☐ **Standardized Plan F**
- ☐ **Standardized Plan F (High Deductible)**
- ☐ **Standardized Plan G**

**RESIDENCE ADDRESS**

*Street:*

*City:*

*State:*  *Zip Code:*

| AGE | DATE OF BIRTH | | | SEX |
|---|---|---|---|---|
| | *Month* | *Day* | *Year* | ☐ Male ☐ Female |

| AREA CODE | TELEPHONE NUMBER |
|---|---|
| | |

**SOCIAL SECURITY NUMBER**

**MEDICARE INFORMATION**

**Medicare Part A Effective Date:** _____

**Medicare Part B Effective Date:** _____

**Medicare Claim Number:** _____

**Effective Date:**  **Special Requests:**

**Mailing Preference:** ☐ Mail to Agent ☐ Mail to Applicant If not answered, policy will mailed to Agent.

**UNDERWRITING RISK CLASSIFICATION QUESTION**

Have you used any form of tobacco in the past five years? ☐ Yes ☐ No

***(You are required to answer this question if you are applying for Life Insurance. You are not required to answer this question if you are only applying for Medicare Supplement Insurance and are in an open enrollment or a guaranteed issue period.)***

## PART I – HEALTH QUESTIONS

**YOU ARE REQUIRED TO ANSWER HEALTH QUESTIONS 1 – 13 IF YOU ARE APPLYING FOR MEDICARE SUPPLEMENT INSURANCE AND ARE NOT IN AN OPEN ENROLLMENT OR GUARANTEED ISSUE PERIOD. PLEASE SEE THE INFORMATION ON PAGE 5 FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION. YOU ARE ONLY REQUIRED TO ANSWER QUESTIONS 1 – 7 IF YOU ARE APPLYING FOR LIFE INSURANCE ONLY.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS BELOW, YOU ARE NOT ELIGIBLE FOR COVERAGE**

1. Are you bedridden, confined to a wheelchair, or require the assistance of a motorized mobility aid; or, in the past two years have you suffered two or more falls within a six month period? ☐ Yes ☐ No
2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
3. In the past two years, has surgery or tests been advised by a physician but not performed? ☐ Yes ☐ No
4. Have you had or been told by your physician you needed amputation due to disease? ☐ Yes ☐ No
5. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:
   a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Lupus, Alzheimer's Disease, or Dementia? ☐ Yes ☐ No
   b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection? ☐ Yes ☐ No
   c. Insulin Dependent Diabetes or any Kidney Disease requiring dialysis? ☐ Yes ☐ No
   d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition? ☐ Yes ☐ No
   e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ☐ Yes ☐ No
   f. Congestive Heart Failure (CHF), or Peripheral Vascular Disease? ☐ Yes ☐ No
6. Within the past two years have you had a heart attack, stroke, or heart valve surgery? ☐ Yes ☐ No
7. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse? ☐ Yes ☐ No

## PART I – HEALTH QUESTIONS CONTINUED – MEDICARE SUPPLEMENT ONLY

**IF YOU ANSWER YES TO ANY OF THE HEALTH QUESTIONS 1-13,**

**YOU ARE NOT ELIGIBLE FOR MEDICARE SUPPLEMENT INSURANCE**

8. Have you had an organ transplant or been advised to have an organ transplant? ☐ Yes ☐ No
9. Is surgery anticipated in the next twelve months? ☐ Yes ☐ No
10. Are you currently using the services of a home health care agency? ☐ Yes ☐ No
11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence? ☐ Yes ☐ No
12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease, Rheumatoid Arthritis, Transient Ischemic Attack (TIA), heart surgery, a cardiac pacemaker replaced or implanted, been treated with a heart defibrillating device, or Hepatitis? ☐ Yes ☐ No
13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture, Muscular Dystrophy, Organic Brain Syndrome, Chronic Kidney Disease, Renal Insufficiency, or Renal Failure? ☐ Yes ☐ No

**Primary Physician Information**

**Name:**

**Address:**

**Telephone:**

## PART II – IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE PART II

**LIFE APPLICATION #:**

**IF YOU ANSWER "YES" TO EITHER QUESTION 1 OR 2, LIFE INSURANCE COVERAGE IS NOT AVAILABLE.**

1. Have you been treated for or diagnosed with a terminal illness? ☐ Yes ☐ No
2. During the last six months, have you been declined for life insurance or had a life insurance application rejected or postponed? ☐ Yes ☐ No
3. Place of Birth (state)? _____

**Initial Amount of Life Insurance Applied for: $**_____

**Amount of Accidental Death Benefit Applied for: $**_____

**Beneficiary:** **Name** _____

**Relationship:** _____ **Date of Birth:** _____/_____/_____

**Address** _____

**Contingent Beneficiary:** **Name** _____

**Relationship:** _____ **Date of Birth:** _____/_____/_____

**Address** _____

**Secondary Addressee:** (An individual who will receive notice of an impending lapse of your life insurance coverage.)

**Name** _____

**Address** _____

Is Automatic Premium Loan provision elected? ☐ Yes ☐ No

Will this life insurance being applied for replace existing life insurance or annuity coverage? ☐ Yes ☐ No

If yes, provide the name of company and policy number(s):

Company:_____Policy Number(s):_____

## PART II – IF APPLYING FOR LIFE INSURANCE CONTINUED

## COMPLETE ONLY IF OWNER OF LIFE INSURANCE POLICY IS NOT PROPOSED INSURED

Owner Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security/Tax ID Number: _____ Date of Birth: _____

Area Code: _____ Telephone Number: _____

Owner Signature: _____

## PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft* ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

***Draft Preference:** ☐ Draft on Effective Date ☐ Draft on Issue If not answered, will draft on issue.

**PREMIUM CALCULATION**

| | |
|---|---|
| **MEDICARE SUPPLEMENT PREMIUM** | **$** |
| **LIFE INSURANCE PREMIUM (including Policy Fee)** | **$** |
| **ACCIDENTAL DEATH BENEFIT RIDER (Optional/Only Available with Whole Life Policy)** | **$** |
| **SUBTOTAL** | **$** |
| **LESS SPOUSAL DISCOUNT (IF APPLICABLE)** | **$** |
| **TOTAL PREMIUM PAID WITH APPLICATION** | **$** |

## PART III – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

   **IF YES,**

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   If yes, with what company? _____

   Company telephone number _____ Policy number _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of plan (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with what company and what kind of policy?

   _____

   Company telephone number _____ Policy Number _____

   (b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## MEDICARE SUPPLEMENT OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-13 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or the individual leaves the plan, whether the plan is primary or secondary with Medicare; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

## AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

## TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

| **Agent's Signature** | **Date** |
|---|---|
| **Agent's Printed Name** | **Agent Number** |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Rate Information

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Supporting Document Schedules

**Satisfied -Name:** Flesch Certification

**Review Status:** Accepted for Informational Purposes 02/03/2009

**Comments:**

**Attachments:**

Flesch Cert .pdf

AR Certificate of Compliance.pdf

**Bypassed -Name:** Application

**Review Status:** 01/29/2009

**Bypass Reason:** Application submitted under Form Schedule Tab

**Comments:**

**Bypassed -Name:** Health - Actuarial Justification

**Review Status:** 01/29/2009

**Bypass Reason:** NA

**Comments:**

**Bypassed -Name:** Outline of Coverage

**Review Status:** 01/29/2009

**Bypass Reason:** NA

**Comments:**

**Satisfied -Name:** Authorization Ltr

**Review Status:** Accepted for Informational Purposes 02/03/2009

**Comments:**

**Attachment:**

2009 01 SILIC Authorization ltr.pdf

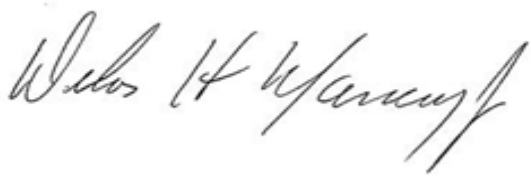
# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Sterling Investors Life Insurance Company**
**Rome Georgia**

I hereby certify that the Flesch Reading Ease Test Score for form number SIMSLAPP20901AR meets the minimum reading ease score of 40 required by IC 27-1-26-3.

Signed for the Company by an Officer



Signature

President

Title

January 16, 2009

Date

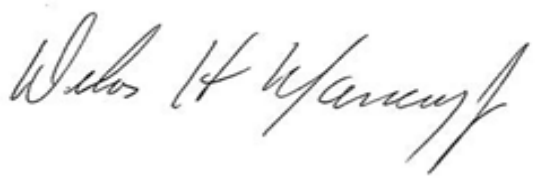
# ARKANSAS COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Sterling Investors Life Insurance Company**
**Rome, Georgia**

The Company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted complies with the requirements of Rules and Regulation 19 and Rule and Regulation 49.

Signed for the Company by an Officer



Title: President

Date: January 16, 2009

STERLING INVESTORS LIFE INSURANCE COMPANY

210 E. Second Avenue
Ste. 105
Rome, Georgia 30161
Tel (706) 235-8154
Fax (866) 889-4054

January 19, 2009

Ms. Darcey Shaffer, ACS, FLMI
Compliance Manager
Wakely and Associates, Inc.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Life and Health Filings for Rate Increases, Forms and Reporting Requirements for Sterling Investors Life Insurance Company

Dear Ms. Shaffer:

This letter authorizes Wakely and Associates, Inc. to file on behalf of Sterling Investors Life Insurance Company, rate increases, forms and reporting requirements for the Company's Life and Health Insurance Policies with the State Insurance Departments. Wakely and Associates, Inc. may correspond with the State Insurance Departments regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

Elwood Whitacre
Secretary and Treasurer

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *WKLY-126013150* | *State:* | *Arkansas* |
| *Filing Company:* | *Sterling Investors Life Insurance Company* | *State Tracking Number:* | *41402* |
| *Company Tracking Number:* | *SILIC AR REV APP* | | |
| *TOI:* | *MS06 Medicare Supplement - Other* | *Sub-TOI:* | *MS06.000 Medicare Supplement - Other* |
| *Product Name:* | *SILIC AR REV APP* | | |
| *Project Name/Number:* | */* | | |

# Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

| Original Date: | Schedule | Document Name | Replaced Date | Attach Document |
|---|---|---|---|---|
| No original date | Form | Application | 01/29/2009 | SIMSLAPP200901AR.pdf |

# STERLING INVESTORS LIFE INSURANCE COMPANY

**Home Office: Rome, Georgia  Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846**

**APPLICATION #:**

**APPLICANT** *(Exactly as shown on your Medicare ID Card)*

*Last*  *First*  *MI*

**Check the Medicare Supplement Plan You Prefer:**

- ☐ **Standardized Plan A**
- ☐ **Standardized Plan B**
- ☐ **Standardized Plan C**
- ☐ **Standardized Plan D**
- ☐ **Standardized Plan E**
- ☐ **Standardized Plan F**
- ☐ **Standardized Plan F (High Deductible)**
- ☐ **Standardized Plan G**
- ☐ **Standardized Plan H**
- ☐ **Standardized Plan I**
- ☐ **Standardized Plan J**

**RESIDENCE ADDRESS**

*Street:*

*City:*

*State:*  *Zip Code:*

| AGE | DATE OF BIRTH | | | SEX |
|---|---|---|---|---|
| | *Month* | *Day* | *Year* | ☐ Male ☐ Female |

| AREA CODE | TELEPHONE NUMBER |
|---|---|
| | |

**SOCIAL SECURITY NUMBER**

**MEDICARE INFORMATION**

**Medicare Part A Effective Date:** _____

**Medicare Part B Effective Date:** _____

**Medicare Claim Number:** _____

**Effective Date:**  **Special Requests:**

**Mailing Preference:** ☐ Mail to Agent ☐ Mail to Applicant If not answered, policy will mailed to Agent.

**UNDERWRITING RISK CLASSIFICATION QUESTION**

Have you used any form of tobacco in the past five years? ☐ Yes ☐ No

***(You are required to answer this question if you are applying for Life Insurance. You are not required to answer this question if you are only applying for Medicare Supplement Insurance and are in an open enrollment or a guaranteed issue period.)***

## PART I – HEALTH QUESTIONS

**YOU ARE REQUIRED TO ANSWER HEALTH QUESTIONS 1 – 13 IF YOU ARE APPLYING FOR MEDICARE SUPPLEMENT INSURANCE AND ARE NOT IN AN OPEN ENROLLMENT OR GUARANTEED ISSUE PERIOD. PLEASE SEE THE INFORMATION ON PAGE 5 FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION. YOU ARE ONLY REQUIRED TO ANSWER QUESTIONS 1 – 7 IF YOU ARE APPLYING FOR LIFE INSURANCE ONLY.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS BELOW, YOU ARE NOT ELIGIBLE FOR COVERAGE**

1. Are you bedridden, confined to a wheelchair, or require the assistance of a motorized mobility aid; or, in the past two years have you suffered two or more falls within a six month period? ☐ Yes ☐ No
2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year? ☐ Yes ☐ No
3. In the past two years, has surgery or tests been advised by a physician but not performed? ☐ Yes ☐ No
4. Have you had or been told by your physician you needed amputation due to disease? ☐ Yes ☐ No
5. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:
   a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Lupus, Alzheimer's Disease, or Dementia? ☐ Yes ☐ No
   b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection? ☐ Yes ☐ No
   c. Insulin Dependent Diabetes or any Kidney Disease requiring dialysis? ☐ Yes ☐ No
   d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition? ☐ Yes ☐ No
   e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ☐ Yes ☐ No
   f. Congestive Heart Failure (CHF), or Peripheral Vascular Disease? ☐ Yes ☐ No
6. Within the past two years have you had a heart attack, stroke, or heart valve surgery? ☐ Yes ☐ No

7. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse? ☐ Yes ☐ No

## PART I – HEALTH QUESTIONS CONTINUED – MEDICARE SUPPLEMENT ONLY

**IF YOU ANSWER YES TO ANY OF THE HEALTH QUESTIONS 1-13,**

**YOU ARE <u>NOT</u> ELIGIBLE FOR MEDICARE SUPPLEMENT INSURANCE**

8. Have you had an organ transplant or been advised to have an organ transplant? ☐ Yes ☐ No
9. Is surgery anticipated in the next twelve months? ☐ Yes ☐ No
10. Are you currently using the services of a home health care agency? ☐ Yes ☐ No
11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence? ☐ Yes ☐ No
12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease, Rheumatoid Arthritis, Transient Ischemic Attack (TIA), heart surgery, a cardiac pacemaker replaced or implanted, been treated with a heart defibrillating device, or Hepatitis? ☐ Yes ☐ No
13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture, Muscular Dystrophy, Organic Brain Syndrome, Chronic Kidney Disease, Renal Insufficiency, or Renal Failure? ☐ Yes ☐ No

**Primary Physician Information**

**Name:**

**Address:**

**Telephone:**

## PART II – IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE PART II

**LIFE APPLICATION #:**

**IF YOU ANSWER "YES" TO EITHER QUESTION 1 OR 2, LIFE INSURANCE COVERAGE IS NOT AVAILABLE.**

1. Have you been treated for or diagnosed with a terminal illness? ☐ Yes ☐ No
2. During the last six months, have you been declined for life insurance or had a life insurance application rejected or postponed? ☐ Yes ☐ No
3. Place of Birth (state)? _____

**Initial Amount of Life Insurance Applied for: $**_____

**Amount of Accidental Death Benefit Applied for: $**_____

**Beneficiary:** **Name** _____

**Relationship:** _____ **Date of Birth:** _____/_____/_____

**Address** _____

**Contingent Beneficiary:** **Name** _____

**Relationship:** _____ **Date of Birth:** _____/_____/_____

**Address** _____

**Secondary Addressee:** (An individual who will receive notice of an impending lapse of your life insurance coverage.)

**Name** _____

**Address** _____

Is Automatic Premium Loan provision elected? ☐ Yes ☐ No

Will this life insurance being applied for replace existing life insurance or annuity coverage? ☐ Yes ☐ No

If yes, provide the name of company and policy number(s):

Company:_____ Policy Number(s):_____

## PART II – IF APPLYING FOR LIFE INSURANCE CONTINUED

## COMPLETE ONLY IF OWNER OF LIFE INSURANCE POLICY IS NOT PROPOSED INSURED

Owner Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security/Tax ID Number: _____ Date of Birth: _____

Area Code: _____ Telephone Number: _____

Owner Signature: _____

## PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft* ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

***Draft Preference:** ☐ Draft on Effective Date ☐ Draft on Issue If not answered, will draft on issue.

**PREMIUM CALCULATION**

| | |
|---|---|
| **MEDICARE SUPPLEMENT PREMIUM** | **$** |
| **LIFE INSURANCE PREMIUM (including Policy Fee)** | **$** |
| **ACCIDENTAL DEATH BENEFIT RIDER (Optional/Only Available with Whole Life Policy)** | **$** |
| **SUBTOTAL** | **$** |
| **LESS SPOUSAL DISCOUNT (IF APPLICABLE)** | **$** |
| **TOTAL PREMIUM PAID WITH APPLICATION** | **$** |

## PART III – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."**

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

   **IF YES,**

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   If yes, with what company? _____

   Company telephone number _____ Policy number _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of plan (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with what company and what kind of policy?

   _____

   Company telephone number _____ Policy Number _____

   (b) What are your dates of coverage under the other policy? START __/__/__ END __/__/__

## IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## MEDICARE SUPPLEMENT OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-13 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:** The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or the individual leaves the plan, whether the plan is primary or secondary with Medicare; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

**Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

## AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or has had read to them, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

## TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

| **Agent's Signature** | **Date** |
|---|---|
| **Agent's Printed Name** | **Agent Number** |